STATE OF WASHINGTON

HIV PREVENTION PROJECT PROGRESS REPORT

Project period: January 1, 2001 – December 31, 2001

SUBMITTED BY

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HIV PREVENTION PROJECT – U65/CCU002018

COOPERATIVE AGREEMENT – PROGRESS REPORT
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A. 5-Year Programmatic Goals (1999-2003)

Below are the overarching programmatic goals for the current five-year period. These goals provide the general framework for guiding future goal development and program planning.

State Goal 1: Increase individual knowledge of HIV serostatus and improve referral systems to appropriate prevention and treatment services.

State Goal 2: Prevent or reduce behaviors or practices that place persons at risk for HIV infection, or if already infected, place others at risk.

State Goal 3: Increase public understanding of, involvement in, and support for HIV prevention.

State Goal 4: Enhance the infrastructure of governmental and nongovernmental organizations to support and deliver effective HIV prevention interventions.

State Goal 1: Increase individual knowledge of HIV serostatus and improve referral systems to appropriate prevention and treatment services.

Objective 1.1: *During 2001, the monthly average number of HIV counseling and testing sessions at publicly-funded sites will be at least 3,000, of which at least 50% of these sessions will serve people with identified or acknowledged risk of HIV.*

2001 Progress: This objective was partially met. The total number of HIV counseling and testing sessions at publicly funded sites was 28,310 with a monthly average of 2,359. Of those tests, 60% were sessions serving people with identified or acknowledged risk for HIV. While publicly-funded HIV counseling and testing sessions continue to decline across the state, the services remain well targeted.

To support this objective, DOH: 1) conducted technical assistance and quality assurance phone calls and site visits; 2) monitored counseling and testing reports to evaluate for high-risk testing efforts and provide sites with technical assistance as appropriate; 3) assured staff providing testing services at publicly-funded sites have received training based on the current CDC model; 4) assured HIV Counseling and Testing trainers were trained and updated; and, 5) provided comprehensive technical assistance to the targeted high-risk testing project team for the Know Your Status Project in Spokane including site visits, meetings, and conference calls covering data collection, program planning and development, evaluation, budgets, etc.

Objective 1.2: *During 2001, at least 75% of persons receiving HIV testing at publicly-funded counseling and testing sites will receive post-test counseling.*

2001 Progress: This objective was partially met. 73% of persons receiving HIV testing at publicly funded counseling and testing sites received post-test counseling. Of the newly identified positives, 96% received post-test counseling.

For relevant training and quality assurance activities, see: objective 1.1 above.

Objective 1.3: *By June 30, 2002, increase the percentage of women, pregnant in the past five (5) years, who report receiving prenatal care and having an HIV test at the time of pregnancy from 59% in the spring of 2000 to 67% in the spring of 2002.*

2001 Progress: Results of the Biennial HIV/AIDS KABB (2002) survey are not available for this report. To support this objective, DOH continues to provide training, technical assistance, and training materials to private providers (including OB/GYNs) with: 1) training on HIV counseling and testing; 2) HIV counseling and pregnancy educational materials (DOH brochures and accompanying videos); and 3) comprehensive recommendations on testing and counseling for pregnant women. DOH maintained the Maternal Child Health/HIV (MCH/HIV), a cross-program, cross-agency workgroup, which was formed to foster effective policies and programs for HIV prevention and care in MCH populations. The group met quarterly. One of the large objectives for 2001 was a proposal for the State Board of Health, which would change the way that pregnant women are offered HIV counseling and testing. Current Washington law mandates "AIDS counseling" for pregnant women, but a woman who wants an HIV test has to ask for one, and sign a separate informed consent. The proposed changes would mirror CDC and ACOG recommendations for pregnant women, and involve informed refusal for HIV testing. The proposal met some initial resistance from activist groups (none of whom specifically represented pregnant women). The proposal will come before the Board in May 2002.

Objective 1.4: *By the end of 2001, at least 95% of newly identified HIV-infected individuals in publicly-funded programs will be interviewed by public health personnel for sexual or syringe-sharing partners.*

2001 Progress: This objective was fully met. The Counseling and Testing data indicate that 40% of the positives identified are previously positive. This high number of previous positive tests is due to second draws at time of results to verify the first, or retesting for HIV-infected individuals wanting verification to access case management services. When the data is adjusted for a 40% previous positive rate, at least 95% of the newly identified HIV-infected individuals were interviewed.

For data support of this objective, DOH has developed a new data collection tool (implemented January, 2002) which includes: 1) explanation of reason for "no interview", and 2) differentiation between newly identified HIV-infected individuals and previously tested positive individuals.

For additional support for this (and other PCRS objectives), DOH continued to support 12.5% each of four experienced STD field personnel to assist in technical assistance for HIV partner counseling and referral activities. These positions are assigned to locations

throughout the state (Spokane, Yakima, Everett, and Olympia) and provide on-site technical assistance and consultation to local staff who have HIV partner counseling and referral service responsibilities. In addition, DOH; 1) conducted technical assistance over the phone and site visits; 2) monitored partner notification reports to evaluate for partner notification efforts and provide sites with technical assistance as appropriate; 3) provided technical assistance to local health jurisdictions for partner notification activities and compliance with the guidance; 4) provided two statewide PCRS training for partner notification and elicitation staff from over 16 local health agencies; 5) provided a statewide partner counseling and referral for services (PCRS) update for advanced PCRS staff; 6) updated the data collection system for PCRS activities (to be implemented during 2002 and to include "reason for no interview" among other improvements); 7) worked with Public Health-Seattle & King County to develop a "person at risk" (cluster model) guidance for PCRS activities and provided a statewide training for this model; 8) disseminated new low-lit PCRS brochures for HIV-infected clients and their partners (Spanish and English); 9) maintained Tacoma-Pierce County for focused TA and provided monthly onsite TA visits; and, 12) provided comprehensive technical assistance to project team for the rural person at risk (cluster notification) Know Your Status Project in Spokane including site visits, meetings, and conference calls covering data collection, program planning and development, evaluation, budgets, etc.

Objective 1.5: *By the end of 2001, at least 25% of HIV-infected persons with identifiable sexual or syringe-sharing partners receiving services at publicly-supported counseling and testing sites will accept public health agency assisted partner counseling and referral services assistance.*

2001 Progress: This objective was partially met. Eighteen percent of HIV-infected persons receiving partner counseling and referral services accepted health agency assistance.

See objective 1.4 above for relevant DOH support for this objective.

Objective 1.6: *By the end of 2001, at least 85% of named, identifiable, and locatable sexual or syringe-sharing partners of persons with HIV will be notified of their exposure by health officials.*

2001 Progress: This objective was fully met. Of the 74 identifiable and locatable partners for public health referral, 85% (63) were notified.

See objective 1.4 above for relevant DOH support for this objective.

Objective 1.7: *During 2001, provide training, quality assurance and on-site technical assistance to at least 10 of the 32 local health jurisdictions providing CTR&PCRS.*

2001 Progress: This objective was fully met. On site CTR&PCRS training, quality assurance, technical assistance and support were provided to over ten sites: Tacoma-Pierce, Seattle-King, SWWA, Snohomish, Spokane, Lewis, Bremerton-Kitsap, Yakima Region 2 office, Spokane Region 1 office, Thurston Region 6 office.

Objective 1.8: *During 2001, implement and support referral and tracking systems to report follow-up success for infected clients to case management, medical treatment and other intervention services in agencies that receive more than $100,000 for HIV prevention activities.*

2001 Progress: This objective was partially met. SHARE data indicated that both programs that receive more than $100,000 have implemented and documented referral.

Objective 1.9: *During 2001, provide 4,500 oral fluid tests for HIV to health departments to continue outreach testing of high-risk populations.*

2001 Progress: This objective was partially met. A total of 3,439 oral fluid tests were conducted during 2001.

State Goal 2: Prevent or reduce behaviors of practices that place persons at risk for HIV infection, or if already infected, place others at risk

Objective 2.1: *During 2001, assure that 75% of CDC funded individual and group level interventions are designed and implemented consistent with scientific sound intervention protocols.*

2001 Progress: This objective was met. Approximately 92% of the CDC funded group and individual level interventions were designed and implemented consistent with scientific sound interventions protocols.

During 2001, to support this objective, DOH: 1) Reviewed each plan submitted to ensure they met the standards set forth on the review form. This included, but was not limited to, reaching the prioritized population in the Regional HIV Prevention Plan, following the plans intervention type selection, study or justification was based on proven effective studies, and other elements were consistent with the Regional HIV Prevention Plan; 2) provided telephonic and face-to-face technical assistance in writing plans; 3) assisted organizations in locating interventions with proven effectiveness which would assist in their prevention efforts; 4) initiated articles in the Washington State Responds which outlined effective interventions; 5) provided examples of intervention plans with proven effectiveness; and, 6) created and distributed templates for counseling and testing and syringe exchange interventions (CDC dollars *NOT* used in connection with any syringe exchange activity).

Objective 2.2: *During 2001, 75% of all developed and reported intervention plans will meet the minimum requirements for established objectives and describe an effective intervention consistent with the State Planning Group's effective intervention guidance.*

2001 Progress: This objective was met. Approximately 78% of the plans developed demonstrated a sufficient delivery plan. Process objectives were measurable, consistent with the goal of the intervention plan, and were specific.

During 2001, to support this objective, DOH: 1) reviewed all plans to ensure process objectives were measurable and specific; 2) developed a training program for writing effective intervention plans; 3) worked with AIDSNET coordinators to ensure they were aware of the standards set for intervention plan writing; 4) provided on site individual and group training in writing intervention plans to approximately 50 persons in varied locations. Feedback from attendees was favorable; and 5) provided telephonic and electronic help to agencies needing technical assistance. The training resulted in more clearly written and defined intervention plans.

State Goal 3: Increase public understanding of, involvement in, and support for HIV prevention.

Objective 3.1: *During 2001 and 2002, maintain the percentage of adults (18 years or older) who state they have attended an HIV/AIDS presentation to at least 40%.*

2001 Progress: Results of the 2002 General Population Survey are not available for this report.

Objective 3.2: *During 2001, continue to provide to the general public and affected individuals and communities technically accurate information and appropriate resource referrals that support risk-reduction behaviors.*

2001 Progress: DOH reviews all HIV/AIDS prevention education curriculum materials submitted by public school districts in Washington State for medical accuracy. DOH also chairs and administers the state's Materials Review Panel, which is in charge of reviewing HIV prevention materials purchased with CDC funds or used by CDC-funded positions. Additionally, we maintain procedures to assure that callers to the statewide HIV/AIDS Hotline receive accurate, consistent and relevant information. There were 8 materials submitted, reviewed and approved for medical accuracy from school districts. Additionally, there were 5 other consults made regarding medically accurate curricula. The state Materials Review Panel reviewed 13 materials for federally funded programs as required by CDC.

The state HIV/AIDS Hotline received an average of 165 calls per month. DOH published 18 articles in the *Washington State Responds* bulletin on HIV related topics including HIV reporting and preliminary results of the new HIV cases reported, treatments, mental health, tuberculosis, the intersections of hepatitis B and C, and effective interventions. Currently, there are 1,350 bulletin subscribers. In 2001, *Washington State Responds* became a quarterly publication (decreasing publication from six times a year to four times.)

In 2001, 446 materials were distributed through the HIV/AIDS Clearinghouse. An additional 72,212 English-language pamphlets and 8,737 Spanish-language pamphlets were distributed through the DOH warehouse. Materials distributed were primarily sent

to local health departments (24%), private physicians, clinics and hospitals (18%), federally funded community and migrant health centers (11%), schools (8%) and other state government agencies (5%).

There were 260 requests for assistance that involved significant staff time for research or that related to safer workplace principles and practices. One-third of the requests came from government agencies and other health departments, one-third came from medical or health care providers, and ten percent came from the general public. An additional 10% of the requests came from DOH staff.

Unfortunately, we were unable to track the number of website hits by month for 2001. The Department of Health has chosen software that can only track the last three months from the time requested. The only numbers available to us for 2001 were December's. In December, there were 1,578 web hits, with 768 unique visitors. The pages that were the most popular were our statistics page, the training schedule for AIDS education required for licensure or certification, and the list of local health jurisdictions where anonymous HIV counseling and testing are available. According to our web statistics program, our main audience appears to be the general public, followed by education professionals and students. For 2002, we are collecting statistics on a monthly basis and will have a more detailed report.

State Goal 4: Enhance the infrastructure of governmental and nongovernmental organizations to support and deliver effective HIV prevention interventions.

Objective 4.1: *During 2001, maintain existing structures and systems to provide staffing, technical support and meeting participation on a variety of internal and external formal and informal workgroups to assure other state agency officials and advisory groups understand the epidemiology of HIV and the importance of supporting HIV prevention efforts.*

2001 Progress. This objective was fully met. HIV Prevention and Education /IDRH staff served on the following state and national workgroups:

1. DOH/Maternal and Child Health Workgroup: provides coordination and input to Child and Family Health Division of DOH on cross program issues of HIV prevention and care. Supports the efforts of the Consumer Advisory Group (CAG), a group of HIV+ women, mothers and supporters.
2. HIV/Department of Corrections Workgroup: provides input on coordination of HIV prevention and care services in the correctional institutions.
3. DOH/Public Health-Seattle & King Co. 'Person at Risk' Workgroup: developed statewide guidance for Person at Risk (cluster) model of PCRS and developed and presented PAR statewide training.
4. DOH STD/HIV/Surveillance Workgroup: developed PCRS and surveillance training.
5. DOH HIV/STD/Case Management/DASA Workgroup: developed and presented an HIV and drug treatment update for case managers, SA treatment staff and HIV counselors.
6. DOH HIV STD/Surveillance/PH-S&KC, Tacoma-Pierce, and Region 3 Workgroup: developed PCRS data collection tool for statewide use.

7. SHARE Meetings: weekly participation in a group to discuss ways to revise the system itself as well as the requirements for data reporting, what, when, how to input data.
8. DOH ADG (Application Developers Group): participate in a forum for agency IT staff, Web developers and Web application owners to discuss best practices and agency level IT decisions.
9. Governor's Advisory Council on HIV/AIDS (GACHA): provides input and advice to the governor on issues effecting HIV prevention and care.
10. AIDSNET Council: serve as staff and member of the governing body of the AIDS Services Network.
11. DOH HIV Study Committee: serve as staff support to the departmental study committee formed to review the efforts of the AIDSNET regions. Final report will be issued in late March or early April 2002.
12. Washington State HIV Prevention Summit: serves as staff and participants in the statewide meeting to review prevention efforts throughout the state and develop recommendations for the direction of HIV prevention over the next five years.
13. NASTAD/CDC: participate in workgroups on Prevention, Community Planning Evaluation, Evaluation and Evaluation Guidance.
14. NASTAD Executive Committee.

During 2001, program staff were assigned specific regions to which they would act as liaisons. Their liaison duties include: 1) development and monitoring of all direct contracts in the region; 2) attendance at regional planning group and other appropriate meetings in the region; 3) on-going technical assistance to the regional coordinator, planning groups and other agencies, organizations and community members; and, 4) assurance that the consolidated contracts and other regional contracts are in compliance with SHARE reporting (data) and other contractual issues. Throughout 2001, the assigned liaison staff were successful in completing all planned tasks and activities. (See Technical Assistance section for more details.)

4.2: *During 2001, support an intervention identified in the year 2000 planning and advisory process to enhance HIV prevention in the American Indian community.*

2001 Progress: This objective was partially met. The results of the needs assessment funded and completed in 2000 were inconclusive in any recommendations for HIV prevention interventions other than provision of additional condoms to the tribal health clinics. Subsequent review of the literature and consultation with American Indian representatives, in 2001, lead to a suspension of an RFP effort until appropriate technical assistance and additional information can be gathered to direct the process. As of 2002, this effort is on-going.

4.3: *During 2001, implement and complete a statewide Latino/Hispanic community needs assessment, with special focus on migrant farm works and rural areas.*

2001 Progress. This objective was partially met. An RFP was issued and contractor identified in September 2001. Completion of the instruments, protocols and procedures

was scheduled for December 2001. IRB review has resulted in a delay in beginning the project. It is anticipated that the assessment will be implemented in late April and completed by December 2002.

4.4: *During 2001, provide support and coordination of statewide workshops and training on, at a minimum: 1) behavioral change theory; 2) program and intervention design; and, 3) theory and development of effective interventions for specific or hard-to-reach populations.*

2001 Progress: This objective was partially met. 1) In November 2001, a statewide workshop on theories of behavioral change and effective interventions was offered as an institute at the Care/Prevention Event, a statewide conference on HIV/AIDS. The primary workshop presenter was Alice Gandelman from the STD/HIV Prevention Training Center in Berkeley, CA (Technical Assistance through AED). Attendance was 65 and the evaluations indicated both satisfaction and increased knowledge. 2) Throughout 2001, the HERR coordinator provided training and workshops for regional planning groups, health departments, CBO's and other agencies on the development and implementation of effective intervention plans. A statewide training was not developed. Instead all regions participated in the individualized training. A total of 50 persons attended the training and evaluations indicated that they were well received. Marked improvement of many of the intervention plans, submitted for the 2002 planning year, was a direct result of this training. 3) The training and workshop on specific effective interventions and populations was limited to 2 regions. Bremerton-Kitsap Health District (Region 5) received training at the March 2001 meeting of the regional planning group. The Seattle-King Co. HIV Prioritization Committee (Region 4) received training on effective interventions for hard-to-reach populations as part of their prioritization process and incorporated this information into their effective intervention recommendations.

4.5: *During 2001, develop and disseminate appropriate sample tools and instruments for the outcome monitoring of group and individual level interventions.*

2001 Progress: This objective was partially met. Until late 2001, the department had not been successful in establishing the procedures to review program evaluation tools and instruments through the state Institutional Review Board (IRB). With the completion of this process, a contractor was identified in September 2001 and the process of developing the outcome monitoring guidance and tools began. The final guidance and instruments should be presented to the State Planning Group (SPG) in April 2002; partially implemented in selected programs in the second half of 2002 and fully implemented in the 2003 intervention plans.

4.6: *By December 31, 2001, jointly, with HIV Client Services Program, participate in the planning and production of the 2001 Statewide Care/Prevention Conference scheduled for October 2001.*
2001 Progress: This objective was fully met. On November 4-7, 2001, the statewide Care/Prevention Event was held at the Double Tree Inn in SeaTac, Washington. Over 500 people registered. 75 workshops, 3 institutes, 2 keynotes and 2 plenary sessions were included. Speakers from the entire State of Washington and several of national reputation presented workshops, institutes and plenary/key notes. Evaluations were very

favorable for all sessions and the event was deemed a great success. All aspects of planning and production were co-coordinated jointly by prevention and care services.

B. CROSS-PROGRAM ACTIVITIES

1. Statement of HIV Prevention, HIV Care, STD and TB Cross-Program Activities

Department of Health - Program Development and Support
The Office of Infectious Disease and Reproductive Health (IDRH) at the Department of Health (DOH) are organized both categorically and functionally. IDRH programs address each of these categorical programs, and, increasingly Hepatitis C. The categorical administrative structure includes HIV Prevention and Education Services; HIV/AIDS Client Services and Early Intervention; STD/TB Services; and Family Planning and Reproductive Health. The Assessment Unit is organized by function. Each of the four major programs in IDRH, including HIV Prevention and Education Services, have contributed staff and resources to the Assessment Unit for surveillance and evaluation activities. The Assessment Unit staff is responsible for monitoring incidence of and risk factors associated with HIV, STD, Hepatitis C, and TB. They work with other program staff to monitor and evaluate STD prevention activities; TB prevention activities; HIV prevention activities; costs and delivery of federally and state-funded HIV clinical services; access to and utilization of HIV outpatient and inpatient services; pregnancy, birth and abortion trends; access to and delivery of publicly funded family planning services; and the needs of family planning clients. Assessment Unit staff also provide support for the Community Resource Inventory (CRI), the Epidemiologic Profile (Epi Profile), and needs assessment activities vital to the HIV prevention community planning process. Assessment Unit staff create data collection instruments that will provide useful information across programs (e.g., sexual behavior questions for the BRFSS survey).

2001 Progress: Collaboration with STD program was fully met. During 2001, the collaborative efforts with the STD program included: 1) joint funding of disease investigation specialist positions by the HIV prevention program and the STD program to provide better support to local disease control efforts and strengthening quality assurance and referral programs; and, 2) training for local disease investigation specialist staff on performing HIV/STD partner notification. The joint project has resulted in increased awareness at local health jurisdictions of resources available for partner notification, which, in turn has resulted in increased requests for technical assistance. Several local workshops and 2 statewide training, with 26 attendees from 17 counties, were conducted by DOH staff. The Partner Notification Guidance was updated and distributed. Additionally, the guidance for the 'person at risk' model was developed and a training completed.

2001 Progress: Collaboration with case management and surveillance was fully met. During 2001, the collaborative efforts with the HIV care and surveillance programs included: 1) joint work between the Assessment Unit and HIV prevention staff at the state and local levels to revise data collection systems to monitor and evaluate

contractors; 2) working with the HIV care services to carry out targeted HIV testing and treatment campaigns to mitigate possible deterrent effects on HIV testing/treatment as a result of HIV reporting; 3) training for local health departments and community-based organizations on a comprehensive confidentiality manual; 4) seeking resources to strengthen Hepatitis C surveillance, prevention, and care services; 5) several tools for outcome monitoring and needs assessment began their development through joint projects with contractors and LHJ staff. Final guidance and tools will be available in mid-2002. Revisions to the SHARE system, resulting from changes in CDC guidelines and the results of a users' survey, were developed and implemented in 2001; 6) HIV care services, working with case managers and consortia, provided on-going materials and support to provide accurate and motivating information about HIV reporting. The number of HIV tests requested have continued to drop since the mid-1990's and there is no evidence that the continuation of this trend is attributable to HIV reporting implemented in 1999; 7) coordination and training for confidentiality has been assumed by HIV Client Services. They continue to support LHJ's and CBO's with training and technical assistance; and, 8) Hepatitis C is now a reportable disease in Washington, but no financial resources were associated with this change. Every effort is being made to maintain a current database of Hepatitis C reports, but the task is difficult without added resources. Efforts to secure these resources in 2001 were unsuccessful.

Local Health Jurisdictions - Service Delivery
There is strong program coordination and collaboration between HIV, STD and TB at the service delivery level. Several health departments have combined their HIV, STD and family planning clinics allowing for fully coordinated service delivery. Most of the large health departments formally provide HIV testing in a combined HIV, STD and family planning clinic or in a STD clinic. In a very few cases, HIV testing is not offered in the STD clinic; however, in such cases, STD clients are directly referred to the HIV clinic for testing and counseling.

When a client tests positive for HIV, he or she is either tested for syphilis and TB by the provider, or directly referred to the STD and TB clinics for immediate testing. Most of the smaller health departments have fully coordinated service delivery: one or two public health nurses provide family planning, HIV, STD, TB, and HBV services.

Many programs are now training their prevention outreach workers in HIV, STD, TB, and Hepatitis. At Public Health - Seattle & King County, HIV is fully integrated into all clinic sites. Staff from cross programs attend regular monthly meetings to identify cross infections and funding needs (e.g.: hepatitis outbreak in food handlers and IDUs). Staff use a team approach to STD, TB and HIV screening, and Hepatitis immunizations (e.g.: both HIV and TB field investigation staff were involved in investigations of a TB outbreak).

2. Statement of HIV and Substance Use Prevention and Treatment, Corrections, and Education Cross-Program Activities

Department of Health - Program Development and Support

DOH HIV prevention and STD staff worked with Division of Alcohol and Substance Abuse (DASA) to co-facilitate a cross training on HIV, STD, TB, and substance use for drug and alcohol treatment counselors and public health workers in 2001. State HIV funding has been provided to DASA to promote HIV testing and early treatment among substance abusers and to increase the capacity of the chemical dependency treatments system to serve individuals with HIV disease. Both departments continue to seek resources to implement the 2000 joint recommendations for blood-borne pathogens prevention and treatment.

DOH HIV programs have provided funding and technical support to the Department of Corrections (DOC) to maintain the Correctional Outreach to Communities for Offenders with HIV/AIDS Project (COCOA) to establish traditional systems to effectively link HIV-infected inmates with case management and early intervention services upon release. DOC is also providing training and technical assistance to local jails and youth detention centers to establish similar systems at the local level. The HIV Prevention Project provides laboratory support for voluntary HIV testing at DOC facilities, and has contracted with a community-based organization for HIV prevention education targeting female inmates.

Representatives of the Department of Corrections, Office of the Superintendent of Public Instruction (OSPI) and DASA are members of the state community HIV prevention planning group (SPG). Both OSPI and DOC are represented on the Governor's Advisory Council on HIV/AIDS. As the HIV prevention program is legislatively mandated to review HIV curricula and materials used in public schools for medical accuracy, the relationship with OSPI is on-going.

Local Health Jurisdictions - Service Delivery
Several of the larger health departments provide the health care services in their local jails while other local jails contract with local providers for these services. Most of the other health departments have staff who conduct HIV education, testing and counseling in the jails and local juvenile detention centers. All the local jails provide HIV counseling and testing for certain convicted detainees (e.g.: sex offenders, prostitutes, IDUs). Most of the HIV programs send staff to local drug rehabilitation programs to conduct HIV education and offer testing. All methadone program clients are offered or referred for HIV testing. Several programs offer HIV, STD, Hepatitis and TB testing at syringe exchanges and provide syringe exchange clients with priority for services at the health department.

C. HIV-PREVENTION COMMUNITY PLANNING

1. National Community Planning Core Objectives for CY 2001

In March 1988, the Washington State Legislature established the 1988 AIDS Omnibus Bill which created the Office on HIV/AIDS (under the Department of Social and Health Service, DSHS) and the six regional AIDS Service Networks (AIDSNETs). The AIDSNETs were charged with developing a plan to meet the needs for HIV education and services within each of the regions. The plan was to reflect the cooperative effort between the local health jurisdictions (LHJ), the community-based AIDS service organizations and other appropriate governmental, non-governmental and private organizations within the region. The county with the largest LHJ in the region was designated as the lead agency. The six regions, with lead agency listed first, are:

REGION 1: Spokane Regional Health District: Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman.

REGION 2: Yakima Health District: Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat and Yakima.

REGION 3: Snohomish Health District: Island, San Juan, Skagit, Snohomish and Whatcom.

REGION 4: Public Health-Seattle and King County: King.

REGION 5: Tacoma-Pierce County Health Department: Kitsap and Pierce.

REGION 6: Southwest Washington Health District: Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum.

The 1988 Omnibus Bill also required that the plan address the following areas: (1) voluntary and anonymous counseling and testing; 2) mandatory testing and/or counseling as required by law; 3) notification of sexual partners and infected people; 4) education of the general public, healthcare professional and individuals at high-risk; 5) implementation of intervention strategies for high-risk individuals; 6) outreach to runaway youth; 7) case management; and, 8) a community-based continuum of care.

All of the AIDSNET regions established regional advisory and/or planning groups to provide a forum for regional planning of prevention and care activities. While no 'formal' community prevention plans were required, each region was required to develop a Regional Service Plan that reflected the outcome of the planning process. Additional planning input was developed through the AIDSNET Council (the directors of the AIDSNET lead LHJs and DOH); the Governor's Advisory Council on HIV/AIDS (GACHA), the Washington State Board of Health and other appropriate statewide groups.

In 1989 the Office on HIV/AIDS was moved to the newly created Washington State Department of Health and the HIV Prevention and Education Services and Client Services Programs were established.

1988 AIDS Omnibus Bill and CDC Community Planning

The 1988 Omnibus Bill, one of the first pieces of comprehensive legislation passed in the United States, established the structure for planning and delivery of HIV/AIDS services in the state. The Bill also established the legal provisions for confidentiality, due process and formula allocation of HIV/AIDS state funds, and where allowable, federal and other funds for prevention and care services. Until 1994, the planning process for utilization of these formula funds was based on each region's internal process and submitted as part of the regional service plan.

Within the implementations of CDC community planning guidance in 1994, each region was charged with the formation of a Regional Planning Group (RPG). The Washington State Department of Health formed the State Planning Group (SPG). To facilitate communication and action between the regional and state planning groups, each regional planning group sends 3 representatives to the state planning group. (See Washington State Comprehensive HIV Prevention Plan for details.) Additional at-large (non-regional) members were included to provide for expertise, community representation and appropriate balance in the membership.

After four years of effort to mesh the AIDSNET system and the CDC community-planning model, it became evident that the system was meeting neither the needs of the region, the state, or the CDC planning process. In October 1997, at the request of the SPG, DOH convened the stakeholders of community planning (co-chairs of the Regional Planning Groups, the State Planning Group and designated representatives of the AIDSNETS and DOH), in Ellensburg, Washington. The purpose of this facilitated 2-day retreat was to review what was working, what wasn't working, and how to improve the community planning process. The result was the Ellensburg Document.

Ellensburg Document and Community Planning

The Ellensburg Document delineated the roles and responsibilities of the stakeholders and was finalized in the Letter of Understanding signed by all stakeholder groups in April of 1999. Within the restraints of the 1988 Omnibus Bill, the Ellensburg Document/LOU designated that 50% of the formula Omnibus funds and, of course, 100% of the CDC funds, must be targeted to the prioritized at-risk populations in the respective plan. The LOU also limited the amount of federal funds (no more than 10%) that could be allocated to state-wide efforts through SPG planning. Additionally, the state planning group's role was defined in terms of the development of planning guidance and technical assistance, while the regional planning groups assumed more

responsibility for prioritization and implementation of effective interventions at the community level.

This process has had a profound and long-term effect on the community planning process in Washington. The time needed to develop and implement guidance on all aspects of the planning process has been lengthy and is not yet complete. Coordinating six separate and independent regional planning groups has proven to involve a learning curve for everyone involved. Progress, however, has been steady and regional plans are beginning to reflect this commitment to quality community planning.

a. Foster the openness and participatory nature of the community planning process.

The current Washington State HIV Prevention Community Planning Group (SPG) consists of thirty (30) members and six (6) alternates. Eighteen (18) members and six (6) alternates are appointed by their respective Regional HIV Prevention Community Planning Group (RPG). Except for monitoring attendance (in response to the SPG Charter), the regional members are completely under the purview of the respective RPG. The remaining twelve (12) SPG members are designated as at-large. At-large members are selected from recruitment and applications from AIDS Service Organizations (ASOs), fields of expertise, infected and affected communities, and other relevant membership categories. The at-large membership are used to bring specific voices to the table. At-large members are appointed by DOH.

The following objectives were addressed in 2001:

Objective 1.a.1: *By January 2001, the SPG will have developed a calendar of meetings; objectives for those meetings; set priorities for activities in 2001 and assigned/developed committee structure and committee membership.*

2001 Progress: This objective was fully met. Calendar, objective, priority activities and committees were complete with the October 26, 2000 meeting.

Objective 1.a.2: *By January 2001, the SPG will have reviewed the SPG/PIR plan and recommended any additions, deletions or other changes. Issues of recruitment, membership gaps, coordination with Ryan White planning and utilization of caucus, interest groups or other methods for input will be included in these recommendations*.

2001 Progress: This objective was fully met. Reviewed, January 25, 2001, no changes recommended.

Objective 1.a.3: *By January 2001, the SPG will have developed and approved a clear statement of roles and responsibilities of regional, at-large and staff members of the SPG.*

2001 Progress: This objective was fully met. A statement of roles and responsibilities of regional, at-large and staff members was developed at the October 25, 2000 and approved at the January 25, 2001 meeting.

Objective 1.a.4: *By January 2001, all members of the SPG will have had the opportunity to review the community planning process and participate in an orientation session.*

2001 Progress: This objective was fully met. A new member orientation was held on March 22, 2001 and the informational booklet (Little Blue Book) was distributed and reviewed by all SPG members at the March 22, 2001 meeting. This booklet summarizes the steps, responsibilities and expectations of the community planning process.

b. Ensure that the CPG(s) reflects the diversity of the epidemic in their jurisdiction and that expertise in epidemiology, behavioral science, health planning, and evaluation are included in the process.

The SPG reflects both the demographics of the epidemic and the expertise needed. The present gaps are MSM of color and Asian-Pacific Islanders. These gaps were addressed in the SPG/PIR planning for 2001. Additional areas of concern included representation from the corrections and mental health fields.

2001 Progress: This objective was partially met. All regions continue to appoint 3 members to the SPG and at-large membership remained high for most of the planning year. Several representatives from the American Indian community resigned or asked to be placed on excused leave for several months. One member of the African-American gay community resigned due to ill health. An at-large member from the Department of Corrections was appointed in 2001. Several statewide community-based organizations also had members selected.

The following table is a summary of the SPG and RPG Membership as of 7/1/01:

MEMBER PROFILE DATA COMPARISON – AS OF July 1, 2001

		State Planning Group*	Regional Planning Groups (Total)	EPI Profile– Persons Living with AIDS
GENDER	Male	70%	51%	90%
	Female	30%	47%	10%
	Transgender	0%	2%	Unknown
AGE	13-24	0%	7%	9%
	25-44	30%	45%	65%
	45-65	60%	46%	24%
	66 and over	4%	2%	2%
SEXUAL IDENTITY	Bisexual	0%	6%	Unknown
	Heterosexual	44%	45%	7%
	Homosexual	56%	39%	63%
	Transgender	0%	2%	Unknown
	Unknown	0%	2%	8%
GEOGRAPHIC LOCATION	Urban	36%	28%	
	Mid-size (<100,000)	36%	31%	
	Rural	18%	41%	
RACE/ ETHNICITY	African American	14%	13%	12%
	Caucasian	76%	80%	75%
	Hispanic/Latino	7%	9%	9%
	Asian- Pacific Islander	0%	2%	2%
	American Indian/ Alaskan Native	3%	5%	2%
	Other	0%	1%	Unknown
HIV STATUS	HIV+	43%	25%	
RISK EXPOSURE (of HIV+)	MSM	41%		
	IDU	17%		
	MSM/IDU	17%		
	Heterosexual	25%		
TOTAL NUMBER OF MEMBERS		**28**	**127**	

*18 members of the State Planning Group are also members of a Regional Planning Group

The RPGs have made great progress in the past year recruiting community members and expertise. While each RPG has its own structure and issues, all of the RPGs have developed a PIR plan. Technical assistance was made available from DOH to address recruitment, retention, training and other membership issues.

The Washington State Department of Health (DOH) HIV Prevention and Education Services office is committed to providing expert staff for consultation and technical assistance in the areas of epidemiology, evaluation, intervention planning, data collected and management and planning support to all HIV prevention planning groups.

c. Ensure that priority HIV-prevention needs are determined based on an epidemiologic profile and a needs assessment.

Target Population Assessment guidance was approved and issued by the SPG. Implementation of target population (needs) assessments; however, was limited by lack of agreement by the state Institutional Review Board (IRB) on whether these efforts constituted research. Negotiations with the IRB have resulted in an understanding of procedures to provide program evaluation studies, i.e. needs assessments, outcome monitoring and other program evaluation without requiring formal IRB review and oversight. In view of this agreement, the Target Population Assessment guidance will be revised and reissued in 2002.

Objective 1.c.1: *By March 2001, revised Washington State HIV Epidemiologic Profile data will be developed and disseminated to all planning groups. Final release of the Epidemiologic Profile will be scheduled in 2001.*

2001 Progress: This objective was partially met. By March 31, 2001 all regional planning groups and the state planning group had received oral and written epi profiles for their respective jurisdictions. A combined Epi Profile was not issued in 2001.

Objective 1.c.2: *By January 2001, DOH will have developed a needs assessment plan on the provision of technical assistance and consultation with the regions to complete any planned target population assessments*.

2001 Progress: This objective was not met. Due to continuing issues around Human Subjects Review requirements for needs assessments, the guidance was issued but very few needs assessments were completed. Dialogue with the IRB in late 2001 clarified the research and program parameters and resolved the roadblocks previously encountered. Needs assessments and guidance will be in place in 2002.

Objective 1.c.3: *By December 2001, a needs assessment of the Latino/Hispanic community, with focus on migrant farm workers and rural areas, will be completed and published.*

2001 Progress: This objective was partially met. A competitive RFP resulted in the award of a contract with the Washington Association of Community and Migrant Clinics. The timeline for this needs assessment will involve collection of data through the fall of 2002 and the issue of the final report in December 2002.

d. Ensure that interventions are prioritized based on explicit considerations of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.

Objective 1.d.1: *By March 2001, the SPG will have reissued the prioritized matrix of effective interventions for the Behavioral Risk Categories and developed a plan for providing technical assistance and consultation to the regions for implementation of effective interventions.*

2001 Progress: This objective was fully met. DOH staff worked closely with regional planning groups to begin identifying the effective interventions appropriate for prioritized populations. This process resulted in a clearer and more up-to-date matrix and more focused prioritization process in several regions. Interventions for 2002 reflected the increased emphasis on utilization of effective interventions. Continued effort in this area is the focus of the 2002 technical assistance plan and process.

Objective 1.d.2: *By December 2001, all decision-making guidance, including the Gap Analysis and Cost Effectiveness guidance will be issued by the SPG.*

2001 Progress: This objective was partially met. Gap Analysis guidance was developed and reviewed. The guidance will be kept in draft form until more experience has been developed through its use. A workshop on the model was presented at the 2001 CPLS Conference in Houston, TX and again in Chicago at the 2002 CPLS. Cost Effectiveness Guidance was not developed in 2001.

Objective 1.d.3: *Through December 2001, provide funding to support and coordinate statewide workshops and trainings on behavioral change theory, program and intervention design, and development of effective interventions for hard-to-reach populations.*

Through the implementation of the SHARE data system (State HIV Activity Reporting and Evaluation), development of effective intervention objectives, process evaluation activities and outcome monitoring will provide increasing data for prioritizing intervention activities.

2001 Progress: This objective was partially met. 1) In November 2001, a statewide workshop on theories of behavioral change and effective interventions was offered as an institute at the Care/Prevention Event, a statewide conference on HIV/AIDS. The primary workshop presenter was Alice Gandelman from the STD/HIV Prevention Training Center in Berkeley, CA (Technical Assistance through AED). Attendance was 65 and the evaluations indicated both satisfaction and increased knowledge. 2) Throughout 2001, the HERR coordinator provided training and workshops for regional planning groups, health departments, CBO's and other agencies on the development and implementation of effective intervention plans. A statewide training was not developed. Instead all regions participated in the individualized training. A total of 50 persons attended the training and evaluations indicated that they were well received. Marked improvement of many of the intervention plans, submitted for the 2002 planning year, was a direct result of this training. 3) The training and workshop on specific effective interventions and populations was limited to 2 regions. Bremerton-Kitsap Health District (Region 5) received training at the

March 2001 meeting of the regional planning group. The Seattle-King Co. HIV Prioritization Committee (Region 4) received training on effective interventions for hard-to-reach populations as part of their prioritization process and incorporated this information into their effective intervention recommendations. SHARE has been successfully used to generate the tables of populations and interventions required in the annual cooperative agreement application. More importantly, SHARE is allowing the regional coordinators and DOH to closely monitor the activities of prioritized interventions throughout the state.

e. Foster strong, logical linkages (i.e. connections) between the community planning process, the comprehensive HIV prevention plan, the application for funding and allocations of HIV-prevention resources.

Through the provisions of the Letter of Understanding and the Ellensburg Document, 100% of all CDC funds and 50% of state Omnibus funds must be allocated to high-risk HIV prevention activities. All non-DOH CDC and Omnibus funds are allocated to each region through a formula and each region is then responsible for allocation and monitoring of the regional expenditures. Ten (10) percent of the CDC dollars (not to exceed $400,000 or be less than $250,000) are 'set-aside' for projects and activities identified as having statewide impact or importance. All of the above expenditures require concurrence of state and regional planning groups, respectively. As a result of the planning process, this concurrence would also include logical connections between the epidemiologic profile for the region or state and the planned expenditures. Annual review of the regional plans by the SPG will further enhance the linkages between community planning and allocation of HIV prevention resources. Gaps will be addressed through technical assistance and consultation with the appropriate planning group, DOH and other partners.

Review of the present intervention plans and expenditures would indicate that the correlation between planned priorities, interventions and expenditures are directly related.

Objective 1.e.1: *By February 2001, the SPG will have reviewed the regional plans and provided a report, with feedback, to the respective region.*

2001 Progress: This objective was fully met. The SPG reviewed all regional plans and provided a written report to each regional coordinator.

Gaps, however, do and will continue to exist. With limited resources each community planning group must make decisions between competing priorities and interests. Often the most at risk populations are the most difficult to reach, especially in rural or isolated areas. This, coupled with the increased per capita costs in rural areas, may greatly limit the extent and scope of interventions. The additional complexity introduced by basing intervention decisions on epidemiological data that is, by definition, retrospective can seriously contribute to gaps if there are significant shifts in the epidemic. It is hoped that the implementation of consistent planning methods, procedures and outcome (through SPG guidance), increased interactions between the regional and state planning groups through mutual participation on these

planning bodies and, finally, feedback through review and technical assistance will result in even closer correlations between the planning and implementation process.

D. HIV PREVENTION PROGRAM

Washington State has a two-year planning cycle. During the 1999 planning process, populations were prioritized for 2000 and 2001. Interventions have been prioritized for each risk transmission group and for subpopulations where specific research information was available.

The specific objectives and activities below are based on the contracts with community-based organizations, which target priority populations with specific interventions. Activities conducted at local health jurisdictions are summarized. The 2001 objectives are based on intervention plans completed by the individual HIV prevention providers. During 2001, Washington State converted to a new data reporting system. Contractors, for the most part, were totally onboard using the new system to gather data concerning their prevention activities. Data for these process objectives and the aggregate forms are taken from three data sets: Statewide HIV Activity Reporting and Evaluation (SHARE) system, Public Health – Seattle & King County, and contract reports.

Goals, objectives, and activities presented reflect only those funded or partially supported through the HIV prevention project. At times, this support is limited to laboratory HIV testing services. Unless otherwise noted, all activities are carried out through contracts with community-based organizations or local health departments/districts.

1. 2001 Programmatic Goals, Objectives, and Activities

Behavioral Risk Category #1: MSM – Urban and Rural
(Includes the following prioritized sub-categories: gay youth; HIV positive persons and their partners; IDU, men of color; multiple sex partners; non-identified MSM; and rural).

Intervention: Health Education Risk Reduction

- **Goal:** Prevent or reduce behaviors or practices that place persons at risk for HIV infection, or if already infected, place others at risk.

- **Objective:** *During 2001, provide 7,233 contacts to MSM through community level intervention, street and community outreach, ~~institution based intervention~~ (this intervention type did not occur), group level interventions, and individual level interventions.*

- **2001 Progress**
  During 2001, the total number of MSM contacted through programs that were conducted with MSM as their prioritized populations was 12,801.

  a. During 2001, six group level interventions with MSM as their prioritized population were funded. Five of the six contacted 3,274 MSM. Of these:

- Stonewall Youth in Grays Harbor, Thurston, Mason, and Lewis County contacted 212 young MSM.
- Spokane Regional Health District (Odessey) contacted 2,038 MSM under 24 years of age.
- Yakima (416) and Whitman (22) Health Departments contacted 438 young MSM.
- University of Washington's Positive Power program contacted 586 MSM.

b. During 2001, The University of Washington was funded to conduct an individual level intervention (Project SHAPE) with MSM as their prioritized population. The intervention reached 253 MSM.

c. During 2001, ten community level interventions with MSM as their prioritized population were funded and contacted 8,071 MSM. Of these:

- The Friend-to-Friend Project (FTFP) contacted 3,386 MSM in five sites, serving eight counties of the state. FTFP is a Community Level Intervention that seeks to reduce the rate of unprotected anal intercourse throughout the MSM community by increasing communication about safer sex and changing the community norm around sexual safety.
- International Community Health Services contacted 2,337 Asian/Pacific Islanders MSM.
- Lifelong AIDS Alliance contacted 178 young MSM under the age of 24 (various races).
- People of Color Against AIDS Network contacted 2,038 MSM. Of those contacted, 1,527 were men of color.
- Gay City (81) and Evergreen AIDS Foundation (51) contacted 132 MSM who attended the Triangle Ranch.

d. During 2001, two prevention case management interventions with MSM as their prioritized population were funded and contacted 804 MSM. Of these:

- Lifelong AIDS Alliance contacted 719 MSM and Madison Clinic contacted 85 MSM. Both interventions are located in Seattle.

e. During 2001, two health communication public information interventions with MSM as their prioritized population were funded. Of these:

- Bremerton-Kitsap Health District contacted 399 MSM during educational presentations.

f. During 2001, the Washington State Department of Health's toll-free HIV/AIDS Hotline and Clearinghouse service provided 1,977 callers with HIV prevention information, connections to early intervention services and other public health resources during working hours (of callers who identified risk, 21% identified themselves as MSM).

Intervention: Counseling, Testing, and Partner Counseling and Referral Services

- **Goal:** Increase the number of MSM who know their HIV serostatus.

- **Objective:** *Provide 1,100 CT&PCR services for MSM (excluding King County). Provide 315 oral fluid CT&PCR services to MSM at all 34 LHJs.*

- **2001 Progress**: This objective was fully met. CT&PCR services were provided targeting MSM in all 34 local health jurisdictions. CT&PCR services were provided 1,656 times targeting MSM. CT&PCR services were provided with oral fluid testing reported on scanforms 498 times targeting MSM. With the adjustment for under-reporting*, the total number of oral fluid tests targeting MSM was 844.

*Oral fluid tests were under-reported across the state. A total of 3,439 oral fluid tests were conducted (State Lab numbers); however, only 2,038 (59%) were reported by counselors (using the scanform). HIV counselors indicate an oral fluid test by filling in a bubble in the "local use" field of the scanform. Few local health jurisdictions use this area of the scanform. Therefore, it was not unusual for HIV counselors to forget about indicating whether the test was an oral fluid test.

Behavioral Risk Category #2: Injection Drug Users (IDU) – Urban and Rural
(Includes the following prioritized sub-categories: females who inject; HIV positive persons and their partners; homeless injectors; methamphetamine injectors; MSM who inject; people of color; rural; and youth).

Intervention: Health Education Risk Reduction

- **Goal:** Prevent or reduce behaviors or practices that place IDU at-risk for HIV infection.

- **Objective:** *During 2001, provide 40,037 contacts with IDUs through group level interventions, ~~institution based intervention~~ (this intervention type did not occur), individual level interventions, street and community outreach, and community level interventions.*

- **2001 Progress:** During 2001, the total number of IDUs contacted through programs that were conducted with IDUs as their prioritized populations was 15,810.

    a. During 2001, two group level interventions with IDUs as their prioritized population were funded and contacted 24 IDUs. Of these:

        - Klickitat contacted 2 and Walla Walla contacted 22 IDUs in correctional facilities.

    b. During 2001, three street and community outreach interventions with IDUs as their prioritized populations were funded and contacted 9,297 IDUs. Of these:

- Blue Mountain Heart to Heart contacted 439 IDUs with their Prevention Plus Program.
- Street Outreach Services in Seattle contacted 6,999 IDUs with their Peer Driven Outreach intervention and 1,859 IDUs with their Harm Reduction Outreach intervention.

c. During 2001, two health communication public information interventions with IDUs as their prioritized population were funded and contacted 6,489 IDUs. Of these:

- Tacoma Urban League contacted 6,422 IDUs in Pierce County
- Bremerton-Kitsap contacted 67 IDUs with their Substance Use Outreach intervention.

d. In 2001, the Washington State Department of Health's toll-free HIV/AIDS Hotline and Clearinghouse service provided 1,977 callers with HIV prevention information, connections to early intervention services and other public health resources during working hours. (of callers who identified risk, 5% identified themselves as IDU.)

Intervention: Counseling, Testing, and Partner Counseling and Referral Services

- **Goal:** Increase the number of IDUs who know their HIV serostatus.

- **Objective:** *Provide HIV counseling, testing and partner counseling and referral services (CT&PCRS) targeting IDU (and others at-risk) in all 34 local health jurisdictions (LHJ). Provide 2,800 sero-antibody counseling/testing services for IDU at 33 LHJ (excluding King County). Provide 810 oral fluid antibody counseling/testing services to IDU at 34 LHJ.*

- **2001 Progress**: This objective was fully met. CT&PCR services were provided targeting IDUs in all 34 local health jurisdictions. CT&PCR services were provided 2,949 times targeting IDU. CT&PCR services were provided with oral fluid testing reported on scanforms 693 times targeting IDU. With the adjustment for under-reporting*, the total number of oral fluid tests targeting IDU was 1,174.

*Oral fluid tests were under-reported across the state. A total of 3,439 oral fluid tests were conducted (State Lab numbers); however, only 2,038 (59%) were reported by counselors (using the scanform). HIV counselors indicate an oral fluid test by filling in a bubble in the "local use" field of the scanform. Few local health jurisdictions use this area of the scanform. Therefore, it was not unusual for HIV counselors to forget about indicating whether the test was an oral fluid test.

Behavioral Risk Category #3: Heterosexual - Urban and Rural
(Includes the following prioritized sub-categories: HIV positive persons and their partners; multiple sex partners; people of color; those who have survival sex; women who have sex with IDUs and/or MSM; rural; and youth).

Intervention: Health Education Risk Reduction.

- **Goal:** Prevent or reduce behaviors or practices that place heterosexuals at risk for HIV infection.

- **Objective:** *During 2001, provide 5,972 contacts with heterosexuals through community level interventions, group level interventions, individual level interventions, health communication public information, and ~~institution based intervention~~ (this intervention type did not occur), street and community outreach intervention.*

- **2001 Progress:** During 2001, the total number of heterosexuals contacted through interventions that were conducted with heterosexuals as their prioritized populations was 14,022.

    a. During 2001, seven group level interventions with heterosexual as their prioritized population were funded. Five of the seven contacted 954 heterosexuals. Of these:

        - POCAAN contacted 624 heterosexual females in a correctional facility.
        - Benton-Franklin contacted 278 heterosexual youth in a correctional facility. Approximately 50% of the contacts were with people of color.
        - Grant County Health Department contacted 31 Hispanic heterosexuals with their seasonal farm worker program.
        - Lincoln County Health Department contacted 8 heterosexuals in a correctional facility.
        - Okanogan County Health District contacted 13 heterosexuals with their Prevention Plus intervention.

    b. During 2001, Adams County was funded to conduct an individual level intervention for heterosexuals. They contacted 223 heterosexuals in a correctional facility.

    c. During 2001, seven street and community outreach interventions with heterosexual as their prioritized populations were funded. These interventions contacted 2,410 heterosexuals. Of these:

        - Benton-Franklin contacted 393 heterosexuals with their seasonal farm worker intervention.
        - Blue Mountain Heart to Heart, in Walla Walla, contacted 144 heterosexuals with two separate interventions. The main focus was on the Latino population.
        - Chelan-Douglas contacted 408 heterosexuals with their high-risk outreach program.
        - Kittitas County Health Department contacted 300 heterosexuals with their migrant farm worker intervention.

- Yakima Health District, contacted 1,165 heterosexuals with two interventions conducting routine outreach and Latino specific outreach.

d. During 2001, three health communication public information interventions with heterosexual as their prioritized population were funded. One of the three, YouthCare in Seattle, contacted 1,347 heterosexual youth under the age of 24.

e. During 2001, Spokane AIDS Network was funded to conduct a prevention case management program with heterosexuals as their prioritized population. They contacted 264 Caucasian, Latino, and American Indian women.

f. During 2001, four community level interventions with heterosexuals as their prioritized population were funded. Three of the four contacted 8,814 heterosexuals. Of these:

- International Community Health Services contacted 329 heterosexual Asian/Pacific Islanders.
- Lifelong AIDS Alliance contacted 8,378 heterosexuals. The majority of those contacts were women of color.
- Good Samaritan Outreach Services contacted 107 Hispanic heterosexuals.

g. During 2001, the Washington State Department of Health's toll-free HIV/AIDS Hotline and Clearinghouse service provided 1,977 callers with HIV prevention information, connections to early intervention services and other public health resources during working hours. (Of callers who identified risk, 37% identified themselves as heterosexuals.)

Intervention: Counseling, Testing, and Partner Counseling and Referral Services

- **Goal:** Increase the number of Heterosexuals who know their HIV serostatus.

- **Objective:** *Provide HIV counseling, testing and partner counseling and referral services (CT&PCRS) targeting heterosexuals (and others at-risk) in all 34 local health jurisdictions (LHJ). Provide 4,500 sero-antibody counseling/testing services for heterosexuals at risk at 33 LHJ (excluding King County). Provide 1,350 oral fluid antibody counseling/testing services to heterosexuals at risk at 34 LHJ.*

- **2001 Progress**: This objective was fully met. CT&PCR services were provided targeting heterosexuals at risk in all 34 local health jurisdictions. CT&PCR services were provided 5,999 times targeting heterosexuals. CT&PCR services were provided with oral fluid testing reported on scanforms 847 times targeting heterosexuals at risk. With the adjustment for under-reporting*, this objective was fully met with 1,436 oral fluid tests targeting heterosexuals at risk.

  * Oral fluid tests were under-reported across the state. A total of 3,439 oral fluid tests were conducted (State Lab numbers); however, only 2,038 (59%) were reported by counselors (using the scanform). HIV counselors indicate an oral fluid test by filling

in a bubble in the "local use" field of the scanform. Few local health jurisdictions use this area of the scanform. Therefore, it was not unusual for HIV counselors to forget about indicating whether the test was an oral fluid test.

2. **Prevention for HIV-Infected Persons Project (PHIPP)** – This does not apply to Washington State.

3. **Perinatal** – This does not apply to Washington State.

4. **Community Coalition Development** – This does not apply to Washington State.

5. **Linkages Between Primary and Secondary HIV Prevention Activities**

***Description of Proposed and Existing Linkages*:**
Primary and secondary HIV prevention activities are linked at the state, regional, and local levels. At the state level, both the manager of the HIV prevention program and the manager of the HIV early intervention program report directly to the AIDS director. The HIV early intervention program provides funding for: antiretroviral and other drug treatments; early medical intervention services including CD 4 and viral load testing, physical examinations, vaccinations, and testing for other STDs; Medicaid waiver services; dental services; case management services; planning and coordination of services; and establishing a local continuum of care. Approximately 300 provider agreements have been established to provide these services. Additionally, a Maternal Child Health/ HIV prevention workgroup has been established to assure linkage of programs and services to prevent perinatal transmission of HIV. Coordination of HIV prevention and care services also occurs at the AIDSNET level through the AIDSNET regional coordinator, and regular meetings of DOH managers and AIDSNET directors and coordinators. Three of six regions 2, 3, and 4 (Seattle-King County), have combined prevention/care community planning groups.

The Title I Council in Seattle-King County care-prevention-collaboration committee is an official, established Title I committee. The committee's immediate focus was to issue an RFP for $65,000 for care-prevention provider cross-training which took place in 2001. A subcommittee prioritized what types of providers and what types of training were included. Year 2001 funds continue to support Prevention Case Management services at two of the largest care/case management providers in Seattle-King County. Planning groups in all regions have been discussing and prioritizing prevention services for HIV+ people, which will involve collaboration with care services.

In three local public health jurisdictions (Seattle-King, Tacoma-Pierce, and Bremerton-Kitsap) the same providers offer both counseling/testing and early intervention services. All local health jurisdictions have available case management services for clients identified with HIV and have referral linkages to medical care providers.

Other linkages include the provision of risk-reduction education for clients through case management and opportunities for joint training of case managers, disease intervention staff, and counselors. The department's publication, *Washington State Responds* includes sections on both prevention issues and care issues.

Goals and Objectives:
The goal of linking HIV prevention and care services is to increase the number of HIV-infected persons who are aware of their serostatus and to assure that those persons receive early intervention and care services. Objectives include:

1. *During 2001, maintain existing structures and systems to link administration and planning of HIV prevention and care services. (on-going objective)*

2001 Progress: This objective was fully met. During 2001, the internal organization of HIV (IDRH) services at DOH continued to support the linkages between STD, HIV prevention and care, TB, Family Planning and Assessment. Numerous workgroups (see State Goal 4.1) are jointly chaired, facilitated or attended by staff from all or most of these offices. In addition to these workgroups, internal organization enhances planning and implementation through:

1. TEAM: weekly meetings and bi-monthly planning days of the program staff responsible for the CTR/PCRS, HERR, community planning and SHARE systems are a critical element in coordination of effort within HIV Prevention and Education Services.

2. Weekly Program Staff Meetings: all non-support program staff meet weekly to coordinate and share efforts.

3. Monthly Manager Meetings: the managers of HIV Prevention and Education Services, HIV Client Services, Assessment, Family Planning and STD/TB meet monthly with the IDRH director to coordinate and share information and planning.

External coordination and linkages are maintained. Refer to State Goal 4.1 for details.

2. *During 2001, establish at least one sentinel site in each of the six regions to report on the follow-up success of referrals for infected clients to case management, medical treatment and other intervention services. (on-going objective)*

2001 Progress. This objective was unmet. During 2001, the decision was made to discontinue the efforts to formally establish sentinel sites. This decision was based on the organizational relationships of DOH to the independent health jurisdictions and the continued erosion of state dollars for local health efforts. As staff and resources became less available, adding new functions and processes became less appealing or acceptable. This objective was not included in the 2002 application.

3. *During 2001, with the HIV care services program, increase the skills of HIV prevention and care workers and promote opportunities for collaboration between the care and prevention service delivery systems. (new objective)*

Strategies and activities to achieve these goals and objectives:

Maintaining existing workgroups to facilitate communications; joint projects to develop policies and procedures; cross-training of prevention and care staff; assisting local agencies in developing referral tracking systems for HIV-infected clients; and, health education/risk reduction activities to improve access to early intervention services.

The first statewide conference (October 2001) addressing both the HIV care and prevention programs was jointly sponsored and funded by the HIV prevention and care programs. The conference provided training workshops and networking opportunities for local HIV prevention and care service providers.

2001 Progress. This objective was fully met.

1. CAREvent: In November 2001, a joint conference on prevention and care was held in SeaTac. The theme of the conference was 'Care/Prevention – Bridging the Gap.' All 75 workshops and 1 institute presented primary information on either care or prevention, with the caveat that the other discipline must also be included in the discussion. Evaluations support the finding that this was generally accomplished.

2. State Planning Group (SPG): The present community co-chair is the director of care services for his community-based organization and membership includes representatives for Substance Abuse Treatment (DASA); Corrections (COCOA Project); Office of the Superintendent of Public Instruction (assurance of medical accuracy of curricula for educational programs); Maternal & Child Health Workgroup Consumer Advisory Committee; DOH/STD/TB program; and, the six AIDSNETs coordinators.

3. Collaborative efforts are continually increasing as more and more programs, agencies and organizations are focusing on HIV+ individuals for prevention efforts.

6. Coordination of HIV Prevention Services and Programs

Description of Coordination Plans:
According to Chapter 70.24.250 of the Revised Code of Washington, "The Office on AIDS shall have the responsibility for coordinating all publicly funded education and service activities related to AIDS." This responsibility is carried out in cooperation with the six regional service networks (AIDSNETs), local public health jurisdictions and their community partners, and statewide organizations such as the University of Washington's Center for Health Education and Research, AIDS Education and Training Center. To be effective, coordination needs to occur at both the state and local levels. Plans for coordination include: 1) maintaining regular opportunities for information sharing and shared decision making with community and local partners; 2) supporting the community planning process at the state and regional levels; and, 3) enhancing evaluation systems and capacities.

Goals and Objectives:
The goal of coordinating HIV prevention services and programs is similar to the goal of the community planning process: to increase the cost efficiency, compatibility and cost effectiveness of HIV prevention funds. Objectives include:

1. *During 2001, the SPG and DOH staff will provide technical assistance to the regional planning groups to fully implement the guidance documents created as a result of the Ellensburg document. (on-going objective)*

2001 Progress: This objective was fully met. During 2001, DOH staff provided technical assistance to RPG's through direct attendance of planning meetings, targeted trainings and other assistance as requested by the RPG or regional coordinator. With the establishment of the regional liaison responsibilities, the liaison staff attend all appropriate planning meetings in their respective regions. The responsibility of RPG members who serve in the state planning group (SPG) is to provide the bridge between the state process (including guidance) and their respective RPG. As a result, the planning groups have successfully implemented guidance on PIR, Decision-Making, Plan Format, Community Planning Evaluation, CRI, and, Effective Intervention Matrix. Several planning groups have implemented the Gap Analysis Guidance. Assessment Guidance and Outcome Monitoring Guidance are under revision or development and will be implemented in the 2003 planning process. Cost Effectiveness Guidance will be delayed until CDC completes its computer assisted CEA guidance. Regional Plan Review Guidance was fully implemented by the SPG. (See Technical Assistance Section for more details on T/A)

2. *During 2001, DOH will collaborate with the six Regional AIDSNETs, local health jurisdictions and community partners to implement the revised SHARE process data collection system. (on-going objective)*

2001 Progress. This objective was fully met. All regions and providers are now on-line and utilizing the SHARE system. The six regional coordinators are utilizing the reporting function to provide support and monitoring of their intervention plans.

3. *During 2001, arrange for presentations by CDC directly funded community-based organizations to the state planning group or the regional planning group. (new objective)*

2001 Progress: This objective was fully met. During 2001, the SPG received reports from Baker Street Ministries (African-American Faith Project), HAPDEU (Friend-to-Friend Project, MSM) and the American Indian Needs Assessment Project. The Regional Planning Groups in Regions 1,3,4,and 5 (Pierce) received reports from their directly-funded and regionally funded projects.

Strategies and Activities to achieve these objectives included:
AIDSNET coordinators and regional representatives on the SPG were queried regarding needs of the regional planning group, for assistance in following Ellensburg guidance. In addition, the planned review of regional plans and funding plans by members of the SPG and DOH staff were shared with the regional coordinators and planning groups.
Initial computer programming for the revised SHARE system was completed. System testing and training for local and regional users was provided to all regions.

The primary mechanism to assure coordination of HIV prevention programs and services is through regular meetings of the following groups and these continued throughout 2001.

Policy Issues: Governor's Advisory Council on HIV/AIDS; AIDSNET Council; MCH/HIV Community Advisory Workgroup.

Planning and Services: State Planning Group; regional planning groups; AIDSNET Coordinators; AIDSNET - local health jurisdiction meetings.

7 b. Monitoring the Implementation of HIV Prevention Interventions

The following tables were generated by SHARE to reflect the HIV prevention interventions for 2001

7 c. Linkages Between The Comprehensive HIV Prevention Plans and HIV Prevention Resources Allocation

This revised matrix reflects the HIV prevention activities that were conducted in 2001, Strikethrough words indicate a deletion of an activity that appeared in the 2001 grant

application. Underlined words indicate the addition of an activity that did not appear in the 2001 grant application.

WASHINGTON STATE
CDC FUNDED PREVENTION ACTIVITIES FOR 2001
BEHAVIORAL RISK POPULATIONS AND INTERVENTIONS
2001 Progress Report Revision

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**

BEHAVIORAL RISK CATEGORY 1:
MEN WHO HAVE SEX WITH MEN (MSM) – URBAN AND RURAL

	HERR	HC/PI	CTRPN
1.	**A. Community Level Interventions** **B. Group Level Interventions** **~~C. Institution Based Interventions (corrections, drug treatment)~~**		**A. CTRPN (focused on high risk)**
2.	**A. Individual Level Interventions** **~~B. Institution Based Interventions (schools)~~** **C. Street/Community Outreach (Syringe Exchange included)**	**A. Mass Media & Other Media** **B. Social Marketing**	
3.	**~~A. Institution Based Interventions (workplace)~~**	**A. Hotline/Clearinghouse**	

1.A: Health Education Risk Reduction, Community Level Intervention		
Provide community level interventions for adult MSM.	Friend-to-Friend community level interventions to MSM are conducted by: Spokane AIDS Network (SAN), Snohomish Health District, Evergreen AIDS Foundation, Thurston County Health District, and Southwest Washington Health District. These projects serve Clark, Island, San Juan, Skagit, Snohomish, Spokane, Thurston and Whatcom counties. Gay City (Seattle) is conducting a community level intervention for Snohomish County at a summer encampment of MSM at Triangle Ranch.	Pierce County AIDS Foundation located in Pierce County also conducts a Friend-to-Friend MSM intervention. This site is supported with private dollars.
Provide community level interventions for MSM of color.	Community level interventions in Seattle-King County are provided to the African American MSM community by POCAAN (People of Color Against AIDS Network) and the Asian/Pacific Islander community through	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 1: MEN WHO HAVE SEX WITH MEN (MSM) – URBAN AND RURAL		
	International Community Health Services.	
Provide community level interventions for MSM 24 years of age or younger.	A CBO will provide a community-level intervention for MSM, 24 years of age or younger in Pierce County. YouthCare provides a community-level intervention for MSM, 24 years of age or younger in Seattle-King County.	
1.B: Health Education Risk Reduction, Group Level Interventions		
~~Provide group level interventions to MSM.~~	~~Stonewall Health Project provides a group level intervention for MSM in Asotin and Whitman counties.~~	
Provide group level interventions for MSM in correctional and/or drug treatment settings (institution based).	Benton-Franklin, Klickitat, Walla Walla, and Whitman counties conduct group level interventions to MSM in correctional and drug treatment settings.	
Provide group level interventions to MSM of color	Okanogan Health Department and Blue Mountain Heart to Heart conduct group level interventions with MSM of color in Columbia and Okanogan counties.	
Provide group level interventions to MSM 24 years of age or younger.	Kitsap and Pierce counties conduct group level interventions for MSM 24 years of age or younger. Stonewall Youth provides a group level intervention for MSM who are 24 years of age or younger in Grays Harbor, Lewis, Mason and Thurston counties.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 1: MEN WHO HAVE SEX WITH MEN (MSM) – URBAN AND RURAL		
	The ~~STARS~~ ROPED project provides a peer led group level intervention to Adams, Asotin, Columbia, Ferry, Pend Orielle, Garfield, Lincoln, Spokane, Stevens, Walla Walla, and Whitman counties and the Colville Indian Reservation.	
Provide group level interventions for HIV positive MSM and their partners.	HAPDEU (University of Washington) conducts a group level intervention called Positive Power for HIV positive MSM.	
~~1.C: Health Education Risk Reduction, Institution Based Interventions~~		
~~Provide institution based interventions in correctional and drug treatment settings to MSM.~~	~~For institution based interventions, refer to individual- or group level interventions. This intervention was re-classified to be consistent with the CDC Final Draft Evaluation Guidance issued in late 1999.~~	
2.A: Health Education Risk Reduction, Individual Level Interventions		
Provide individual level interventions to MSM.	Adams County Health Department conducts individual level interventions targeting incarcerated MSM.	
Provide individual level interventions to HIV positive MSM.	Project SHAPE (Seattle-King County) conducts individual level interventions targeting HIV positive MSM.	
		Prevention Case Management for MSM is provided by the ~~Northwest AIDS Foundation (NWAF)~~ Lifelong AIDS Alliance and Madison Clinic (Harborview Hospital) in Seattle-King County.
~~2.B: Health Education Risk Reduction, Institution Based Interventions~~		

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 1: MEN WHO HAVE SEX WITH MEN (MSM) – URBAN AND RURAL		
~~Provide institution based in other than correctional or drug treatment settings.~~	~~Recommendation not addressed with CDC funding~~	
2.C: Health Education Risk Reduction, Street and Community Outreach Interventions		
Provide street and community outreach to MSM of color.	Benton-Franklin, Chelan-Douglas, Kittitas, and Yakima Health Districts conduct street and community outreach to migrant farm worker and Latino communities in their respective counties.	
~~3.A: Health Education Risk Reduction, Institution Based Interventions~~		
~~Provide institution based in other than correctional or drug treatment settings.~~	~~Recommendation not addressed with CDC funding.~~	
2.A: Health Communication Public Information, Mass Media Interventions		
Provide mass media or other media interventions targeting MSM.	Recommendation not addressed with CDC funding.	
2.B: Health Communication Public Information, Social Marketing Interventions		
Provide social marketing interventions to MSM.	Recommendation not addressed, although elements of social marketing can be found in Seattle-King County interventions.	
3.A: Health Communication Public Information, Hotline/Clearinghouse Intervention		

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 1: MEN WHO HAVE SEX WITH MEN (MSM) – URBAN AND RURAL		
Provide Hotline/Clearinghouse services to MSM.	The Washington State Department of Health's HIV/AIDS Hotline and Clearinghouse can be accessed by citizens through a toll-free line.	
1.A: Counseling, Testing and Partner Counseling and Referral Services		
Provide Counseling, Testing, Partner Counseling and Referral Services.	All local health jurisdictions (LHJ) in the state of Washington are required to provide CT& PCRS to MSM. All LHJ utilize the state laboratory for processing all serologic antibody tests (except King County) and oral fluids test (including King County). Those LHJ that have submitted intervention plans for CDC funding are: Asotin, Clallam, Clark, Cowlitz, Ferry, Grays Harbor, Island, Jefferson, Kitsap, Lewis, Mason, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, and Wahkiakum counties.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**

BEHAVIORAL RISK CATEGORY 2:
INJECTION DRUG USERS (IDU) - URBAN AND RURAL

	HERR	HC/PI	CTRPN
1.	**A. Group Level Interventions (women and people of color)** **~~B. Institution Based Interventions (corrections, drug treatment)~~** **C. Street/Community Outreach (Syringe Exchange)**		**A. CTRPN (focused on high risk)**
2.	**A. Individual Level Intervention** **B. Street/Community Outreach**		
3.	**A. Community Level Interventions** **~~B. Institution Based Interventions~~**	**A. Mass Media & Other Media** **B. Social Marketing** **C. Hotline/Clearinghouse**	

1.A: Health Education Risk Reduction, Group Level Intervention		
Provide group level interventions for IDU targeting women and people of color.	Street Outreach Services (SOS) conducts group level interventions to IDUs population specifically targeting women and people of color in Seattle-King County.	
Provide group level interventions to IDU of color.	Okanogan Health Department and Blue Mountain Heart to Heart conduct group level interventions with IDUs of color in Columbia and Okanogan counties.	
Provide group level interventions for youth at risk.	Stonewall Youth provides a group level intervention for IDUs who are MSM and 24 years of age or younger in Grays Harbor, Lewis, Mason, and Thurston counties. The ~~STARS~~ ROPED project provides a peer led group level intervention to Adams, Asotin, Columbia, Ferry, Garfierld, Lincoln, Okanogan, Pend	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 2: INJECTION DRUG USERS (IDU) - URBAN AND RURAL		
	Orielle, Spokane, Stevens, Walla Walla, and Whitman counties and the Colville Indian Reservation.	
Provide group level intervention a correctional or drug treatment institution based setting.	Benton-Franklin, Klickitat, Lincoln, Walla Walla, and Whitman counties conduct group level interventions in correctional and drug treatment settings to IDUs.	
~~**1.B: Health Education Risk Reduction, Institution Based Intervention**~~		
~~Provide institution based interventions for IDU in correction and/or drug treatment settings.~~	~~For institution based interventions, refer to individual or group level interventions. This intervention was re-classified to be consistent with the CDC Final Draft Evaluation Guidance issued in late 1999.~~	
1.C: Health Education Risk Reduction, Syringe Exchange		
Provide syringe exchange services for IDU.	This recommendation not addressed through CDC funding.	
2.A: Health Education Risk Reduction, Individual Level Intervention		
Provide individual level intervention to IDU.	Adams County conducts individual interventions for IDU.	
		Prevention Case Management for IDU is provided by the ~~Northwest AIDS Foundation (NWAF)~~ Lifelong AIDS Alliance and Madison Clinic (Harborview Hospital) in Seattle-King County.
2.B: Health Education Risk Reduction, Street and Community Outreach Interventions		
Provide street and community outreach to IDU.	Blue Mountain Heart to Heart conducts street and community outreach to IDU populations in Columbia, Walla Walla and Whitman counties.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 2: INJECTION DRUG USERS (IDU) - URBAN AND RURAL		
Provide street and community outreach to IDU of color.	Chelan-Douglas, Kittitas and Yakima Health Districts conduct street and community outreach to migrant farm worker and ~~Latin~~ Latino communities in their respective counties.	
3.A: Health Education Risk Reduction, Community Level Interventions		
Provide community level interventions for IDU.	IDUs (among others at-risk) are provided a community-level intervention by International Community Health Services in Seattle. .	
~~3.B: Health Education Risk Reduction, Institution Based Interventions~~		
~~Provide institution based interventions in non-correction and/or drug treatment settings for IDU.~~	~~Recommendation not addressed with CDC funding.~~	
3.A: Health Communication Public Information, Mass Media Interventions		
Provide media interventions to IDU.	Recommendation not addressed with CDC funding.	
3.B: Health Communication Public Information, Social Marketing Interventions		
Provide Social Marketing interventions for IDU.	Recommendation not addressed, although elements of social marketing can be found in Seattle-King County interventions.	
3.C: Health Communication Public Information, Hotline/Clearinghouse Interventions		
Provide Hotline/Clearinghouse services to IDU.	The Washington State Department of Health's HIV/AIDS Hotline and Clearinghouse can be accessed by citizens through a toll-free line.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 2: INJECTION DRUG USERS (IDU) - URBAN AND RURAL		
1.A: Counseling, Testing and Partner Counseling and Referral Services		
Provide Counseling, Testing, & Partner Counseling and Referral Services.	All local health jurisdictions (LHJ) in the state of Washington are required to provide CT&PCRS to MSM. All LHJ utilize the state laboratory for processing all serologic antibody tests (except King County) and oral fluids test (including King County). Those LHJ that have submitted intervention plans funded through CDC are: Asotin, Clallam, Clark, Cowlitz, Ferry, Grays Harbor, Island, Jefferson, Kitsap, Lewis, Mason, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, and Wahkiakum counties.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**

BEHAVIORAL RISK CATEGORY 3:
HETEROSEXUAL – URBAN
(Includes King, Pierce, Snohomish Counties)

	HERR	HC/PI	CTRPN
1.	**A. Community Level Interventions** **B. Group Level Interventions** **~~C. Institution Based Intervention (corrections, drug treatment)~~**		**A. CTRPN (focused on high risk)**
2.	**A. Individual Level Interventions** **~~B. Institution Based Interventions (schools)~~**	**A. Mass Media & Other Media** **B. Social Marketing**	
3.	**~~A. Institution Based Interventions (workplace)~~**	**A. Hotline/Clearinghouse**	

1.A: Health Education Risk Reduction, Community Level Interventions

Provide community level interventions targeting heterosexuals of color at risk for HIV transmission in urban counties.	People of Color Against AIDS Network (POCAAN) conducts a community level intervention targeting African American heterosexuals in Seattle-King County. International Community Health Services conducts a community level intervention targeting Asian/Pacific Islander heterosexual in Seattle-King County. Good Samaritan Counseling and Outreach Services' Latino Project conducts Spanish language group level interventions for at-risk heterosexuals in Pierce County.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 3: HETEROSEXUAL – URBAN (Includes King, Pierce, Snohomish Counties)		
1.B: Health Education Risk Reduction, Group Level Interventions		
Provide group level interventions for heterosexuals 24 years of age or younger in urban counties.	YouthCare conducts a group level intervention for heterosexual (among others at-risk) who are street-involved in Seattle-King County.	
Provide group level interventions targeting heterosexuals of color in urban counties.	A CBO provides group level interventions with at-risk heterosexual women and their partners in the African American, Latino and Asian/Pacific Islander communities in Pierce County. POCAAN provides a group-level intervention to incarcerated women at the Women's Correctional Center in Purdy located in Pierce County.	
~~1.C: Health Education Risk Reduction, Institution Based Institutions~~		
~~Provide institution based interventions in correctional or treatment settings in urban counties.~~	~~Recommendation not addressed with CDC funding.~~	
2.A: Health Education Risk Reduction, Individual Level Interventions		
Provide individual-level interventions targeting heterosexuals at risk in urban counties.		Prevention Case Management for heterosexuals is provided by the ~~Northwest AIDS Foundation (NWAF)~~ Life Long AIDS Alliance and Madison Clinic (Harborview Hospital) in Seattle-King County.

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 3: HETEROSEXUAL – URBAN (Includes King, Pierce, Snohomish Counties)		
~~2.B: Health Education Risk Reduction, Institution Based Interventions~~		
~~Provide institution-based interventions targeting high risk heterosexuals in the schools.~~	~~Recommendation not addressed with CDC funding.~~	
~~3.A: Health Education Risk Reduction, Institution Based Interventions~~		
~~Provide institution based interventions targeting professional in the workplace that may be at increased risk of occupational exposure and/or serving people who may be infected in the workplace.~~	~~Recommendation not addressed with CDC funding.~~	
2.A: Health Communications Public Information, Mass Media		
Provide a media campaign for heterosexuals in an urban county.	Recommendation not addressed with CDC funding.	
2.B. Health Communications Public Information, Social Marketing		
Provide Social Marketing interventions for IDU.	Recommendation not addressed, although elements of social marketing can be found in Seattle-King County interventions.	
3.C: Health Communication Public Information, Hotline/Clearinghouse intervention		
Provide Hotline/Clearinghouse services to heterosexuals in urban areas	The Washington State Department of Health's HIV/AIDS Hotline/Clearing-house can be accessed by citizens through a toll free line.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORAL RISK CATEGORY 3: HETEROSEXUAL – URBAN (Includes King, Pierce, Snohomish Counties)		
1.A: Counseling, Testing and Partner Counseling and Referral Services		
Provide counseling, testing & partner counseling and referral services (CT&PCRS) to at-risk heterosexuals in urban counties.	All local health jurisdictions (LHJ) in the state of Washington are required to provide CT&PCRS to MSM. All LHJ utilize the state laboratory for processing all serologic antibody tests (except King County) and oral fluids test (including King County).	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**

BEHAVIORIAL RISK CATEGORY 4: HETEROSEXUALS – RURAL			
	HERR	**HC/PI**	**CTRPN**
1.	**A. Community Level Interventions** **B. Group Level Interventions** **~~C. Institution Based Interventions (corrections, drug treatment)~~**	**A. Mass Media & Other Media** **B. Social Marketing**	**A. CTRPN (focused on high risk)**
2.	**A. Individual Level Interventions** **~~B. Institution Based Interventions (schools)~~** **C. Street/Community Outreach (syringe exchange)**		
3.	**~~A. Institution Based Intervention (workplace)~~**	**A. Hotline/Clearinghouse**	

1.A: Health Education Risk Reduction, Community Level Interventions	
Provide community level interventions for at-risk heterosexuals in rural counties.	Recommendation not addressed with CDC funding.

1.B: Health Education Risk Reduction, Group Level Interventions		
Provide group level interventions to at-risk heterosexuals in rural counties.	Benton-Franklin, Lincoln, Whitman, and Kittitas provide a group level intervention in institutional settings. Grant County conducts group level interventions for heterosexual sex workers. The ~~STARS~~ <u>ROPED</u> project provides a peer led group level intervention to Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman counties and the Colville Indian Reservation.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORIAL RISK CATEGORY 4: HETEROSEXUALS – RURAL		
Provide group level interventions to at-risk heterosexuals of color.	Okanogan Health Department and Blue Mountain Heart to Heart conduct group level interventions with at risk heterosexuals of color in Columbia and Okanogan counties.	
~~**1.C: Health Education Risk Reduction, Institution Based Interventions**~~		
~~Provide institution based interventions in correction and/or drug treatment settings for at-risk heterosexuals in rural counties.~~	~~For institution based interventions, refer to individual- or group level interventions. This intervention was re-classified to be consistent with the CDC Final Draft Evaluation Guidance issued in late 1999.~~	
2.A: Health Education Risk Reduction, Individual Level Interventions		
Provide individual level interventions for at-risk heterosexuals.	Adams County (institutional setting) conducts an individual level intervention for at-risk heterosexuals.	
~~**2.B: Health Education Risk Reduction, Institution-Based Interventions**~~		
~~Provide institution-based interventions for at-risk heterosexuals in schools.~~	~~Recommendation not addressed with CDC funding.~~	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORIAL RISK CATEGORY 4: HETEROSEXUALS – RURAL		
2.C: Health Education Risk Reduction, Street and Community Outreach Interventions		
Provide street and community outreach for at-risk heterosexuals of color.	Benton-Franklin, Chelan-Douglas, Kittitas, Walla Walla, and Yakima counties conduct street and community outreach to at-risk heterosexuals of color.	
~~**3.A: Health Education Risk Reduction, Institution Based Interventions**~~		
~~Provide institution based interventions targeting professional in the workplace that may be at increased risk of occupational exposure and/or serving people who may be infected in the workplace.~~	~~Bremerton-Kitsap County Health Department provides HIV prevention to licensed health care professionals, health care facility workers, public safety and school employees.~~	
1.A: Health Communication Public Information, Mass Media		
Provide media interventions targeting at-risk heterosexuals in rural counties.	~~Grant County conducts media interventions for at-risk heterosexuals.~~ Yakima County conducts Spanish-language media campaigns through KDNA radio.	
1.B. Health Communications Public Information, Social Marketing Interventions		
Provide social marketing interventions for at-risk heterosexuals in rural counties.	Recommendation not addressed with CDC funding.	

	INTERVENTIONS IN CDC FUNDING APPLICATION	
Recommendations in the Plan	**…that match a recommendation in the plan**	**…that do not match a recommendation in the plan**
BEHAVIORIAL RISK CATEGORY 4: HETEROSEXUALS – RURAL		
3.A Health Communication Public Information, Hotline/Clearinghouse Interventions		
Provide Hotline/Clearinghouse services to heterosexuals in urban counties. .	The Washington State Department of Health's HIV/AIDS Hotline/ Clearinghouse can be accessed by citizens through a toll-free line.	
1.A: Counseling, Testing and Partner Counseling and Referral Services		
Provide counseling, testing, referral and partner notification (CTRPN) to at-risk heterosexuals.	All local health jurisdictions (LHJ) in the state of Washington are required to provide CT&PCRS to MSM. All LHJ utilize the state laboratory for processing all serologic antibody tests (except King County) and oral fluids test (including King County). Those rural counties for which intervention plans were submitted for CDC funding are: Asotin, Clallam, Clark, Cowlitz, Ferry, Grays Harbor, Island, Jefferson, Kitsap, Lewis, Mason, Pacific, Pend Oreille, San Juan, Skagit, Spokane, Stevens, Thurston, and Wahkiakum counties.	

PREGNANT WOMEN – URBAN AND RURAL (INTERVENTIONS NOT PRIORITIZED)		
Health Education Risk Reduction, Group-Level Intervention		
The plan requested for regions to consider pregnant women. No specific recommendations were made.		Among other populations, pregnant women of color are targeted through group level interventions in Okanogan and Yakima counties. Group level intervention provided in Benton-Franklin county targeting pregnant women (among others) in correctional settings. .
Health Education Risk Reduction, Street and Community Outreach Interventions		
		Street and community outreach targeting Hispanic pregnant women (among others) in Benton-Franklin counties.
	Maintain the Maternal Child Health/HIV Workgroup, a collaborative effort which includes members from the Department of Health, the Department of Social and Health Services and community partners. The MCH/HIV workgroup also has established a community advisory group comprised of HIV service providers/insurers and women infected/affected by HIV/AIDS from around the state. The MCH/HIV workgroup has developed and distributed: provider and patient education materials encouraging women contemplating pregnancy or pregnant to seek HIV counseling and voluntary testing and materials on resources for medical providers and patients on the topic.	
GENERAL PUBLIC		
Health Communication/Public Information, Mass Media		
		Media based interventions targeting MSM (and others at-risk) are conducted in Garfield and Whitman counties.

7 d Progress in Implementation Evaluation Plan
Comprehensive Evaluation Plan

Activity	Steps	Timeline
Evaluate the HIV Community Planning Process	1. Profile of Community Planning Group members. 2. Table of estimated expenditures. 3. Write guidance for evaluation of the community planning process. 4. Process evaluation of State Planning Group activities.	1. Completed and ongoing 2. Completed and ongoing 3. Completed and ongoing 4. Completed and ongoing
Intervention Plans	1. Develop a user-friendly, web-based computer system to write intervention plans and capture process data for HIV prevention activities ("SHARE" system operational 9/00). 2. Receive intervention plans for HIV prevention activities from all health departments and CBOs receiving both state and federal HIV prevention dollars.	1. Completed 2. Completed and ongoing
Linkages	1. Review intervention plans from AIDSNET regions to ascertain whether prevention dollars are being spent on populations and activities prioritized in the regional prevention plans.	1. Completed and ongoing
Process Monitoring	1. Develop a user-friendly, web-based computer system to write intervention plans and capture process data for HIV prevention activities ("SHARE" system operational 9/00). 2. Analyze data from system on a quarterly basis to ascertain whether activities described in intervention plans are reaching targeted populations.	1. Completed and ongoing 2. Completed and ongoing
Process Evaluation	1. Evaluate all interventions (special emphasis on individual and group-level) for conformity with effective intervention program design and appropriate intervention delivery through analysis of SHARE data and site visits.	1. Completed and ongoing

Outcome Monitoring	1. Evaluate prevention program outcomes for changes in risk behaviors using pre- and post-test design when appropriate. For this purpose: a. Develop sample tools and instruments (and get IRB approval if needed). b. Add module to SHARE system to capture pre/post data (if resources available).	1a. Begun in 2001, anticipated completion in 2002. 1b. 2003 and ongoing
Outcome Evaluation	1. Identify statewide prevention program appropriate for outcome evaluation with necessary staff and resources (Friend to Friend, community level intervention). 2. Identify comparison sites in Idaho and Oregon; develop methodologies and instruments. 3. Collect and analyze data.	1. Completed 2. Completed 3. 2001-2003

8. Technical Assistance

Technical assistance was be available from DOH or an appropriate provider in the following areas:

Prevention Programs

A. Provision of quality assurance of counseling and testing activities in publicly funded sites.

2001 Progress: During 2001, DOH:

1. Conducted technical assistance and quality assurance phone calls to all local health departments providing counseling and testing services, and on site training, quality assurance, technical assistance and support was provided to over ten sites: Tacoma-Pierce, Seattle-King, SWWA, Snohomish, Spokane, Lewis, Bremerton-Kitsap, Yakima Region 2 office, Spokane Region 1 office, Thurston Region 6 office.
2. Monitored counseling and testing reports to evaluate for high-risk testing efforts and provide sites with technical assistance as appropriate.
3. Assured staff providing testing services at publicly funded sites have received training based on the current CDC model.
4. Assured HIV Counseling and Testing trainers were trained and updated.
5. Provided technical assistance to the targeted high-risk testing project team for the Know Your Status Project in Spokane including site visits, meetings, conference calls, and phone calls covering data collection, program planning, and development, evaluation, and budgets, etc.

B. Provision and quality assurance of partner counseling and referral services in publicly funded sites.

2001 Progress: During 2001, DOH continued to support 12.5% each of four experienced STD field personnel to assist in technical assistance for HIV partner counseling and referral activities. These positions are assigned to locations throughout the state (Spokane, Yakima, Everett, and Olympia) and provide on-site technical assistance and consultation to local staff who have HIV partner counseling and referral service responsibilities. In addition, DOH:

1. Conducted technical assistance over the phone and site visits.
2. Monitored partner notification reports to evaluate for partner notification efforts and provide sites with technical assistance as appropriate.
3. Provided technical assistance to local health jurisdictions for partner notification activities and compliance with the guidance.
4. Provided annual training of partner notification and elicitation for staff from over 16 local health agencies.
5. Provide a statewide partner counseling and referral for services (PCRS) update for advanced PCRS staff.
6. Updated the data collection system for PCRS activities (to be implemented during 2002 and to include “reason for no interview” among other improvements.

7. Worked with Seattle-King County to develop a "person at risk" (cluster model) guidance for PCRS activities and provided a statewide training for this model.
8. Designed and printed new low-lit PCRS brochures for HIV-infected clients and their partners (Spanish and English).
9. Established Tacoma-Pierce County for focused TA and provided monthly onsite TA visits.
10. Provided comprehensive technical assistance to project team for the rural person at risk (cluster notification) Know Your Status Project in Spokane including site visits, meetings, and conference calls covering data collection, program planning, and development, evaluation, budgets, etc.

C. Provision and quality assurance of partner notification by private providers.

2001 Progress: During 2001, DOH established a team to work on this objective. The team developed a training to assure a smooth linkage between reported HIV cases and local health jurisdiction support of provider PCRS activities. This training will be presented during 2002. The team also established the need for updated provider brochures also to be developed in 2002. DOH has no quality assurance role with private providers except through licensure issues. Efforts to influence private provider practices, however, will continue.

D. Partner elicitation for partner notification services.

2001 Progress: See second bullet above: "Provision and quality assurance of partner counseling and referral services in publicly funded sites".

E. Referral Tracking

2001 Progress. During 2001, guidelines for making referrals were developed and will be added to the SHARE system in the next major revision. How these referrals will be tracked is a local decision and will be reviewed over the next year.

F. Confidentiality and security of HIV records.

2001 Progress. The HIV Confidentiality and Security Manual was reprinted by HIV Client Services and distributed to all publicly funded HIV care programs in Washington State. All prevention and care programs were reminded that a 2-3 hour training is available. DOH staff provided one training to a CBO, at their request.

Planning Process

A. Effective intervention design
B. Process and outcome objectives development

2001 Progress. During 2001 DOH:

1) Provided 296 telephonic technical assistance calls
2) Responded to approximately 120 email technical assistance questions
3) Conducted effective intervention plan writing workshops in five of the six regions, reaching approximately 50 individuals
4) Reviewed all intervention plans and provided written feedback to the submitting agency

C. Implementation of SPG planning guidance at the RPG level.

2001 Progress. See sub-section 6. Coordination of HIV Prevention Services and Programs.

D. Implementation of PIR plans.

2001 Progress. During 2001, all regional planning groups had a PIR plan in place and no technical assistance was requested.

E. Epidemiologic information, state and regional.

2001 Progress. During 2001, the lead assessment epidemiologist prepared and presented regional epi profiles to all planning groups. These were included as an attachment to the 2002-2003 HIV Prevention Plan. The State Planning Group (SPG) received a statewide report at the March 2001 meeting. Additional technical assistance was not requested.

F. Developing target population assessments.

2001 Progress. During most of 2001, needs assessments were placed on hold until an agreement with the state Institution Review Board (IRB) could be reached to define the limits of program evaluation and research. In September 2001, an agreement was reached to implement needs assessments and outcome monitoring as tools for program evaluation. Guidance for the Target Population Assessments (now called Prioritized Population Needs Assessment Guidance) was revised and will be presented to the SPG in March 2002. Outcome Monitoring Guidance development has involved a behavioral science contractor and a statewide committee. The committee should make final recommendations in time for the guidance to be presented at the April 2002 SPG meeting.

Data Collection and Program Monitoring

Participation and utilization of the SHARE (Statewide HIV Activity, Reporting and Evaluation) System.

2001 Progress. All regions and providers received training and technical assistance on participation and utilization of SHARE. The HIV Prevention and Education Services database manager responded to 224 phone calls and 90 emails regarding questions about how to use SHARE, how to overcome operating errors, and the regular maintenance of the worker and user lists in the system.

Other requests

2001 Progress:

1) As requested during 2001, Regions 3 and 5 (Kitsap) received assistance in the prioritization process.
2) As requested, Region 6 received technical assistance in the allocation of resources and implementation of an intervention for MSM.
3) Region 1 and 2 received technical assistance in planning an HIV+ project called 'Know Your Status.' (see Innovative Practices section)

9. Innovative Practices

The following activities are viewed as innovative:

A. KNOW YOUR STATUS PROJECT.

This project will provide services to selected counties in eastern Washington. It is a modification of the Dr. Jordan OASIS model in Los Angeles and involves utilization of HIV+ persons as 'case-finders' for other potentially HIV+ individuals. The methodology involves the identification and recruitment of people within the social/behavioral target population for an intensive individual intervention that is designed to result in CTR and referral for services appropriate to the risk behavior and serostatus. It is hoped that the successful development of this intervention will provide other rural areas with a potentially powerful intervention. Dr. Wilbert Jordan is a consultant on this project and has arranged for full evaluation of the process.

B. Statewide HIV Activity Reporting and Evaluation System (SHARE).

SHARE continues to become a progressively supportive data base system and each modification enhances its 'useability' and reliability. Because of the close linkage between the intervention plans, process objective monitoring and budget, the utilization of the system is increasing the awareness of these interrelationships. Additionally, the process of training and reviewing the intervention plans has the added benefit of reinforcing the concepts and practices of prioritizing populations and associated effective intervention requirements.

C. CARE(Prevention)vent.

For the first time, CAREvent (a previously strictly care focused conference) included prevention issues. The theme of the statewide conference was "Care/Prevention – Bridging the Gap." Approximately 500 individuals were registered, including case managers, HIV+ clients, prevention workers, social workers, counselor/testers, administrators and other community members. Over 75 workshops were presented with the request that both care and prevention issues be covered in each. Three 3-hour institutes was included and covered the topics of involving HIV+'s, cultural competency and effective intervention planning. Evaluations indicated a great deal of satisfaction with the joint conference and enthusiasm for repeating it in two years.

10. Special Issues

There are no special issues at this time.